BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Michael S. Basch, M.D. Physician's and Surgeon's Certificate No. A 62314 Respondent	Case No. 800-2015-014249

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 21, 2019

IT IS SO ORDERED July 22, 2019

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, MD

Ronald Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
COLLEEN M. MCGURRIN
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Attorneys for Complainant

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: MICHAEL S. BASCH, M.D. 41593 Winchester Road, Suite 101 Temecula, California 92590 Physician's and Surgeon's Certificate No. A 62314 Respondent.	Case No. 800-2015-014249 OAH No. 2018050994 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. MICHAEL S. BASCH, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq. of Doyle Schafer McMahon, LLP, whose address is: 5440 Trabuco Road, Irvine, California 92620.

3. On or about May 9, 1997, the Board issued Physician's and Surgeon's Certificate No. A 62314 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-014249, and will expire on April 30, 2020, unless renewed.

JURISDICTION

4. The First Amended Accusation No. 800-2015-014249 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on October 18, 2018. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2015-014249 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2015-014249. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent freely, voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2015-014249, if proven at a hearing, constitute cause for imposing discipline

upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 62314 issued to Respondent MICHAEL S. BASCH, M.D., shall be and is hereby Publicly Reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient A as set forth in First Amended Accusation No. 800-2015-014249, is as follows:

1. On or about April 30, 2013 through May 7, 2013, in caring for Patient A, you failed to perform a formal and complete cognitive assessment of the patient's functional capacity to screen for and adequately support your diagnosis of dementia in violation of Business and Professions Code section 2234, subdivision (c).

B. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s), which shall not be less than 20 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

C. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to both

the Continuing Medical Education (CME) requirements for renewal of licensure and the Education Course(s) required by Condition B above.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

D. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/19/2019

MICHAEL S. BASCH, M.D.
Respondent

I have read and fully discussed with Respondent MICHAEL S. BASCH, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: May 20, 2019

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 5/20/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2015-014249

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 18 20 18
BY K. Voong ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: MICHAEL S. BASCH, M.D. 41593 Winchester Road, # 101 Temecula, California 92590 Physician's and Surgeon's Certificate No. A 62314, Respondent.	Case No. 800-2015-014249 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 9, 1997, the Board issued Physician's and Surgeon's Certificate Number A 62314 to Michael S. Basch, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2001.1 of the Code states:

"Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by

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existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

". . .

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

7. Section 2266 of the Code, states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL SUMMARY

8. Between March 2008 and August 2013, Respondent worked as a physician at Talia Medical Group, which is located at 41593 Winchester Road, #101, in Temecula, California.

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Patient A

9. Respondent first saw Patient A[1] on or about April 30, 2013. At the time of that visit, Patient A was a 92-year-old woman with a medical history of heart disease, hypertension, osteoporosis, gouty arthritis, and osteoarthritis. Prior to this initial meeting, Patient A's daughter informed Respondent that Patient A suffered from dementia and bipolar illness. Patient A's daughter requested hospice care[2] for her mother. Patient A's daughter also reported that Patient A was severely dependent on pain medications. During this initial visit, Respondent performed a detailed review of Patient A's systems and an extensive physical examination. Patient A's body mass index was 17.54. There were no particular symptoms elicited and the physical examination revealed no abnormalities. Importantly, there were no abnormal psychiatric symptoms reported in Respondent's chart notes. Patient A was alert and oriented. She denied any unusual anxiety or depression. Respondent ordered laboratory studies and reviewed Patient A's current medications.

10. Respondent next saw Patient A on or about May 7, 2013. Respondent reviewed Patient A's laboratory results and renewed her pre-existing prescription medications initially prescribed by her primary care physician(s). Patient A's laboratory studies were unremarkable as she had normal hemoglobin, albumin, and renal function. Patient A's body mass index was 17.36 at this visit. Patient A denied any fatigue, weakness, or shortness of breath. Again, Respondent denied any unusual anxiety or depression symptoms. Patient A was alert and oriented. Importantly, Respondent did not perform a functional capacity assessment during this visit to determine if Patient A was able to perform her simple activities of daily living.

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[1] The patient herein is referred to as Patient A to protect her privacy.

[2] Hospice care is a model of medical care that is designed to provide comprehensive interdisciplinary palliative care for patients with life-limiting illness and a prognosis of six (6) months or less if the disease follows its natural course. Hospice care is appropriate for patients entering the last weeks or months of life, and when patients or their families decide to forego further curative therapies. Hospice care can also be offered to patients with declining functionality who are also suffering from an end stage non-cancer diagnosis such as heart attack, chronic obstructive pulmonary disease, cirrhosis, renal failure, dementia, and failure to thrive.

11. Respondent diagnosed Patient A with failure to thrive.[3] However, Respondent did not complete a detailed history of the patient focusing on timing and symptoms of frailty, disability, and neuropsychiatric impairment. Respondent failed to explore underlying weight loss and feeding factors such as dysphagia, diarrhea, and nausea. Respondent did not document or assess Patient A's ability to perform activities of daily living or her living situation. Moreover, Respondent did not conduct a mental status exam or geriatric depression scale to evaluate Patient A for dementia or depression, which are often a part of failure to thrive syndrome. Finally, Respondent did not order additional laboratory testing or radiologic imaging to exclude any chronic illnesses and cancer diagnoses.

12. Respondent also diagnosed Patient A as having dementia[4] with mental incapacity on or about May 7, 2013. However, Respondent did not utilize cognitive testing to screen and diagnose dementia illnesses, such as the Mini-Mental Status Exam (MMSE), the Cognitive Abilities Screening Instrument (CASI), or the Montreal Cognitive Assessment (MOCA). Similarly, Respondent did not order brain scans or additional laboratory testing to exclude the reversible causes of dementia. Respondent also did not refer Patient A for in-depth neuropsychological testing administered by a psychiatrist. In total, Respondent did not complete any formal cognitive testing or assessment of Patient A's functional capacity.

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[3] Failure to thrive is a syndrome of global decline in older adults that often manifests in the form of weight loss (greater than five percent in a twelve-month period), decreased appetite, poor nutrition, inactivity, and physical exhaustion or weakness. This syndrome occurs in older adults as physical frailty worsens and is frequently compounded by cognitive impairment and functional disability. Failure to thrive is a nonspecific manifestation of an underlying physical, mental, or psychosocial condition. Patients often experience difficulty in completing self-care and independent living tasks. Delirium, depression, and dementia are the most common conditions impairing cognitive status in older adults and, therefore, they are the leading causes of failure to thrive in the geriatric population.

[4] Dementia is a decline and loss of memory, reasoning, judgment, language, and behavior that are not part of the normal aging process. It progressively worsens over time and is irreversible. As the disease progresses, patients will often suffer from mood swings, personality changes, paranoia, poor judgment, and an inability to learn new information. In the later stages of dementia, a patient will have complete loss of short-term and long-term memories. Hallucinations often manifest in late stage dementia. Consequently, dementia patients are dependent upon others for normal daily activities such as bathing, dressing, feeding, and personal hygiene. The risk of malnourishment can lead to frequent infections and mechanical falls that are dangerous. Alzheimer's dementia is responsible for approximately fifty (50) to seventy (70) percent of dementia cases. There is no known cure for dementia and the medial duration of survival is about eight (8) years from the time of diagnosis.

13. After her second and last visit with Respondent, and after knowing Patient A for only about one week, Respondent accepted Patient A into a local hospice program based on the diagnoses of dementia with declining functional status and failure to thrive syndrome. However, Respondent's chart notes did not reflect a terminal prognosis of six months or less for Patient A. Rather, Patient A's cardiopulmonary, liver, and kidney functions were not end stage. She had no documented active cancers.

14. Although Patient A did not have more clinical visits with Respondent after May 7, 2013, she continued to be under his medical care in the hospice program for the next several months. Starting on or about May 13, 2013, Respondent prescribed 10 milligram tablets of hydrocodone, 0.5 milligram tablets of lorazepam, and 20 milligram tablets of morphine to Patient A. These medications were filled by Advance Care Pharmacy while she remained in hospice care. Patient A was also treated with antipsychotic medication and psychiatric care at Respondent's direction.

15. In July 2014, Patient A underwent an independent psychological and mental capacity assessment, but not at the request or direction of Respondent. The psychiatrist found that Patient A was capable of decision making with regards to her health, finances, estate planning, and her last will and testament. According to this assessment, Patient A was functioning at a high level of cognitive ability given her age.

16. Patient A lived for approximately three more years after she was placed in the local hospice program pursuant to Respondent's diagnoses of dementia and failure to thrive. Patient A ultimately passed away in June 2016 from complications of skin cancer treatment.

Patient B

17. Respondent first saw Patient B[5] on or about March 31, 2008. At the time of this initial visit, Patient B was a 42-year-old woman with multiple medical conditions including breast cancer, carpal tunnel syndrome, epilepsy, scoliosis, chronic lower back pain, and leg surgeries. She also had an extensive psychiatric history including depression, generalized anxiety, schizophrenia, and bipolar disorder. Patient B was in a drug detoxification program in 2009 for

[5] The patient herein is referred to as Patient B to protect her privacy.

oxycodone abuse. Patient B started seeing Respondent for primary care and pain management in 2008. She continued as a patient under Respondent's care until her death on January 12, 2012.

18. During this period of time, Respondent routinely prescribed to Patient B a Fentanyl transdermal patch[6] at 50 micrograms per hour for chronic pain. The dosage of the Fentanyl transdermal patch was eventually increased to 75 micrograms per hour in 2010. While Respondent was prescribing the Fentanyl transdermal patch to Patient B, she was also receiving prescriptions for benzodiazepines[7] from her mental health and neurology providers on a regular basis. Respondent was aware of Patient B's use of benzodiazepine and he continued to prescribe the Fentanyl transdermal patch to Patient B through January 2012, thereby increasing her risk for accidental overdose to the combination of the drugs. Respondent did not utilize a less potent or shorter acting opiate medication during this period of time.

19. Between March 2008 and January 2012, Respondent did not utilize a multidisciplinary approach to managing Patient B's chronic pain. Respondent did not utilize nonsteroidal anti-inflammatory drugs (NSAIDs), tricyclics, muscle relaxants, yoga, or physical therapy as alternatives to reduce the potential for Patient B's dependency on opiates. Similarly, Respondent did not refer Patient B for cognitive behavioral therapy as part of the pain management protocol.

20. Patient B's last documented clinical visit with the Respondent took place on March 8, 2011. However, Respondent continued to prescribe the Fentanyl transdermal patch to Patient B over the following nine-month period. Patient B received her last Fentanyl patch prescription

[6] A Fentanyl transdermal patch, commonly sold under the brand name "Duragesic," is a high potency and long acting drug that is used to help relieve severe ongoing pain for patients. Fentanyl is classified as a Schedule II substance under the Controlled Substance Act and is known for its high potential for abuse, with use potentially leading to severe psychological or physical dependence. Fentanyl belongs to a class of drugs known as opioid (narcotic) analgesics. It works in the human brain to change how the body feels and responds to pain. Fentanyl may be habit forming, especially with prolonged use.

[7] Benzodiazepines are a class of psychoactive drugs that enhance the effect of the neurotransmitter gamma-aminobutyric acid (GABA) at the GABA receptor, resulting in sedative, hypnotic (sleep-inducing), anxiolytic (anti-anxiety), anticonvulsant, and muscle relaxant properties. Benzodiazapeines are classified as a Schedule IV substance under the Controlled Substance Act. When combined with other central nervous system (CNS) depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases for the patient.

prior to her death on January 12, 2012. Respondent's medical records do not note any visits or consultations with Patient B after March 8, 2011.

21. Respondent's medical records for Patient B failed to properly document her elevated opioid risks including her history of depression, schizophrenia, bipolar disorder, and past oxycodone abuse. In fact, Respondent's medical records for Patient B were deficient in detailing the intensity pain scale, the potential side effects of the opiate[8] medications, the functional goals of pain management, and urine drug testing results. Moreover, Patient B continued to experience chronic pain despite notations in the medical record that she had no musculoskeletal pain.

22. Patient B was found unresponsive in her mother's home on January 12, 2012. Patient B was pronounced dead at approximately 8:25 a.m. Patient B was wearing a Fentanyl transdermal patch when examined by the Riverside County Sheriff-Coroner's Office. Toxicology testing was conducted which confirmed the presence of Fentanyl in Patient B's system at the time of her death. Patient B's cause of death was subsequently identified as Acute Fentanyl Intoxication by the Riverside County Sheriff-Coroner's Office.

STANDARD OF CARE

23. **Diagnosis of Dementia.** The community standard of care in medical practice in the State of California is to use cognitive testing to screen and diagnose dementia illnesses in a patient. A physician must utilize one of several reliable tests such as the Mini-Mental Status Exam (MMSE), the Cognitive Abilities Screening Instrument (CASI), or the Montreal Cognitive Assessment (MOCA). Furthermore, a physician should consider ordering brain scans and laboratory testing to exclude reversible causes of dementia. When diagnosis is not clear based upon the screening tests, laboratory testing, and brain scans, then a physician should refer the patient for in-depth neuropsychological testing administered by a psychiatrist.

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[8] Opioids are narcotic medications that act on opioid receptors in the human body to produce morphine-like effects. These drugs are primarily used for pain relief. Side effects of opioids may include itchiness, sedation, nausea, respiratory depression, constipation, and euphoria. Tolerance and dependence will develop with continuous use of opiates, requiring increasing doses and leading to a withdrawal syndrome upon abrupt discontinuation. The euphoria attracts recreational use and frequent, escalating recreational use of opioids typically results in addiction. An overdose or concurrent use with other depressant drugs commonly results in death from respiratory depression.

24. **Diagnosis of Failure to Thrive.** The community standard of care in medical practice in the State of California is to conduct a physical examination of the patient, as well as a detailed history focused on timing and symptoms of frailty, disability, and neuropsychiatric impairment before making the diagnosis of failure to thrive. A physician must explore other factors related to weight loss and feeding such as dysphagia, diarrhea, and nausea. Nutritional supplements and/or a speech therapy evaluation can be done to asses for any swallowing pathology that can be corrected. The physician's physical examination should assess the patient's living situation and his/her functional ability to perform activities of daily living, which may later require a social worker visit to the patient's home. Physical and occupational therapy can be offered to improve the patient's functional impairments. Moreover, a physician should conduct a mental status exam or geriatric depression scale to evaluate for dementia or depression, which are often a part of failure to thrive syndrome. If appropriate, a physician can prescribe anti-depressants and anti-dementia medications along with psychotherapy. Finally, limited laboratory testing and radiologic imaging should be done to exclude any chronic illnesses and cancer diagnoses.

25. **Eligibility for Hospice Care.** The community standard of care in medical practice in the State of California is to offer hospice care to terminally ill cancer patients who are suffering from cancer pains and are not expected to survive more than six months. However, hospice care can also be offered to patients with declining functionality who are suffering from end stage non-cancerous diagnoses such as heart failure, chronic obstructive pulmonary disease, cirrhosis, renal failure, dementia, and geriatric failure to thrive. Ultimately, hospice is appropriate for patients that are entering the last weeks to months of life when the patient and their families decide to forego further life-prolonging therapies or treatments.

26. **Monitoring and Reassessment of Chronic Opiate Pain Management.** The community standard of care in medical practice in the State of California is to monitor a patient's progress while using opioid medication for both benefit and harm, including the patient's level of pain, function, analgesia, activities of daily living, quality of life, adverse side effects, and aberrant behaviors. The patient's risk of drug addiction and aberrancy should also be assessed to mitigate potentially adverse consequences of opiate therapy. This involves performing a

psychological evaluation assessing risks of addictive behaviors and referral to a psychiatrist, if warranted, for ongoing treatment, as well as monitoring with regular urine drug testing and consultations with the state prescription drug monitoring program. A patient whose pain is adequately controlled at a safe dosage of opiate therapy must be monitored on a regular basis every one to three months by her physician in order to determine if the pain medication is meeting the patient's goals of improved pain and functional status.

27. **Concurrent Prescriptions for Benzodiazepine and Opiate Medications.** The community standard of care in medical practice in the State of California is for physicians to strongly avoid prescribing both narcotic and benzodiazepine medications to a patient because the risks to the patient outweigh the benefits. Benzodiazepine and opiate medications both cause central nervous system depression and can decrease respiratory drive. Concurrent use of both medications by a patient likely places the patient at greater risk for a potentially fatal overdose. When confronted with a patient on both medications, a physician should taper the patient off of the opiate medication first unless the patient would prefer to continue opiate therapy, in which case the physician must taper off the benzodiazepine medication. A physician should also consult with psychiatry staff for cognitive behavior therapy.

28. **Proper Maintenance of Medical Records.** The community standard of care in medical practice in the State of California is for a physician to maintain accurate and adequate medical records. A physician treating a patient who is prescribed opiate medications should maintain a medical record that includes documentation of medical history, results of physical examination, and all the necessary laboratory and radiologic tests. Discussion of patient consent for using controlled substances and pain management agreements should also be included in the medical record. A physician's medical record for a patient should reflect all treatment provided, including all medications prescribed and any consultations. The results of ongoing monitoring of patient progress or lack of progress in pain management, including urine drug testing, and functional improvement should be documented by the physician, as well as steps taken in response to any aberrant behaviors in opiate usage.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent's license is subject to disciplinary action under Section 2234, subdivision (c) of the Code, in that Respondent committed repeated negligent acts during his care and treatment of Patients A and B. The circumstances are as follows:

30. Complainant refers to and, by this reference, incorporates paragraphs 8 through 28 above, as though fully set forth herein.

31. The following acts and omissions, considered individually and collectively, constitute repeated negligent acts in Respondent's practice as a physician and surgeon:

A. Failing to perform a formal and complete cognitive assessment of Patient A's functional capacity to screen for and adequately support Respondent's diagnosis of dementia.

B. Diagnosing Patient A with failure to thrive despite laboratory findings and observations that did not support Respondent's diagnosis, as well as failing to explore other causes for Patient A's slightly below normal body mass index.

C. Accepting Patient A into the hospice program when there were no signs or symptoms of end state dementia or geriatric failure to thrive syndrome.

D. Lack of proper monitoring and reassessment of Patient B's chronic opiate pain management, including opioid risk and clinical pain, while prescribing a Fentanyl transdermal patch.

E. Prescribing an opiate medication to Patient B who was concurrently using a benzodiazepine medication prescribed by her other health care providers.

F. Failing to maintain adequate and accurate medical records with regards to the care and treatment provided to Patient B.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and/or Inaccurate Medical Record Keeping)

32. By reason of the facts set forth in paragraphs 17 through 22 above, Respondent's license is further subject to disciplinary action under Section 2266 of the Code, in that

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Respondent failed to maintain adequate and accurate records relating to his provision of services to Patient B.

33. Respondent's acts and/or omissions as set forth in paragraphs 17 through 22 above, whether proven individually, jointly, or in any combination thereof, constitute Respondent's failure to maintain adequate and accurate records relating to his provision of services to Patient B, pursuant to Section 2266 of the Code.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

34. By reason of the facts set forth in paragraph 8 through 28 above, Respondent is subject to disciplinary action under Section 2234, subdivision (a) of the Code, in that Respondent has engaged in unprofessional conduct based upon repeated negligent acts in the care and treatment of Patients A and B, and his failure to maintain adequate or accurate medical records concerning the care and treatment of Patient B.

35. Respondent's acts and/or omissions as set forth in paragraphs 8 through 28 above, whether proven individually, jointly, or in any combination thereof, constitute Respondent's unprofessional conduct based upon repeated negligent acts in the care and treatment of Patients A and B, and his failure to maintain adequate or accurate medical records concerning the care and treatment of Patient B, pursuant to Section 2234, subdivision (a) of the Code.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 62314 issued to Michael S. Basch, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to Section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering Michael S. Basch, M.D. to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 18, 2018

for

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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